Final Technical Report

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Research on X-ray Nonlinear Optics and Single-Particle Applications

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1. Brief overview of technical results

The AFOSR grant F49620-93-1-0220 was activated on March 1, 1993 with the project period of three years ending on February 29, 1996. The research of this principal investigator has been supported by AFOSR continuously for 17 years by now. During this period, under AFOSR support, the principal investigator authored or coauthored about 250 publications, among them about 10 book contributions, 80 regular journal papers, one patent, and 26 conference proceedings papers; the rest are conference papers.

Under the AFOSR grant F49620-93-1-0220, 60 new papers have been published by this principal investigator and his group, among them 19 papers in regular journals [1-19], 2 book contributions [20,21], 10 conference proceedings papers [22-31], and the rest are conference papers [32-60].

Most of the effects proposed under the AFOSR support are novel and have initiated new opportunities in the field. The work by this PI is highly credited by the research community in the field. Within the last five years, for example, his work was cited for about 400 times (according to "Science Citation Index ") by other researchers. He has been a member of program committees and a panel member of several technical conferences on nonlinear optics and quantum electronics, and an editorial board member of the "International Journal of Nonlinear Optical Physics and Materials".

Under AFOSR grant F49620-93-1-0220, a number of new results were obtained by this principal investigator and his group in the field of nonlinear optics and quantum electronics:

- i. Pioneering theoretical research on X-ray nonlinear optics, aimed to diversify coherent X-ray sources by means of nonlinear frequency transformations (mixing of X-ray and optical radiation, stimulated Raman scattering, etc.)
- ii. Theoretical research on phase-matching optimization of large-scale nonlinear frequency upconversion, with a potential to substantially improve the efficiency of this new source of short-wavelength coherent radiation.
- iii. Theory of high-harmonic generation in super-dressed two-level atoms.
- iv. Theory of modulation-induced inhibition of dynamics and high-order frequency mixing in two-level atoms.
- v. Bright-bright 2π -Solitons in stimulated Raman scattering.
- vi. Pilot theoretical research on the subfemtosecond soliton formation and propagation, in particular, on subfemtosecond pulses in mode-locked 2π -solitons of the cascade stimulated Raman scattering, and the so called electromagnetic bubbles.
- vii. Experimental research on biological applications of nonlinear laser spectroscopy (two-photon induced fluorescence).

viii. Other research: eigenmodes of $\chi^{(2)}$ wave-mixings and X-ray narrow-line transition radiation source based on low-energy electron beams traversing a multilayer nanostructure.

2. Technical reports on specific projects

2.i. Research on X-ray nonlinear optics [5,7,8,20,22,25,27,29,30,31,32,36,46,47]

Recent years have witnessed a steady progress in X-ray laser (XRL) research: several XRLs near 200 $^{\circ}A$ demonstrated saturation and high degree of spatial coherency, with the output of $\sim 1~MW$; the Y XRL at LLNL attained very high output of $\sim 40~MW$; mirrors and polarizers were developed; cavity operation and cascade X-ray amplification were tried; and some promising steps to table-top X-ray lasers were made.

At the same time, XRL applications are still in the very early stages, being limited essentially to Y XRL interferometry of plasma for ICF research and a few experiments with X-ray microscopy. The relatively high cost of existing XRLs is not the main obstacle to their applications, since even XRLs already developed could be much less expensive if realized on specialized equipment, not to mention using them as national facilities. More important is that XRL applications to spectroscopy, microscopy, and technology would require large variety of sources, especially at high frequencies, and availability of tunable coherent X-rays. At longer wavelengths (IR, visible, UV), coherent radiation sources are diversified largely by nonlinear optical transformations. In X-ray domain, due to very limited number of XRLs with substantial output (out of ≈ 50 reported X-ray laser lines less than 10 demonstrate high output), At the same time, the output power of some XRLs is comparable to the Q-switched output of optical lasers and seems to be high enough for efficient nonlinear transformations in highly-resonant nonlinear media.

Using a theoretical base created by us under the previous AFORS grants, we have theoretically explored, under current AFOSR support, a large variety of nonlinear frequency transformations with potentially high conversion efficiency [20,22,27,29,30,31,32,46,47]. We have also considered in detail X-ray stimulated Raman scattering in gases and vapors [5,7,8,25,36], which renders the first relatively efficient X-ray frequency transformation in non-ionized media ever proposed. Finally, we did a pilot research on the feasibility of multiphoton processes in X-ray domain, which could open a way to generating coherent radiation at very short (of a few $^{\lambda}$) wavelengths [30].

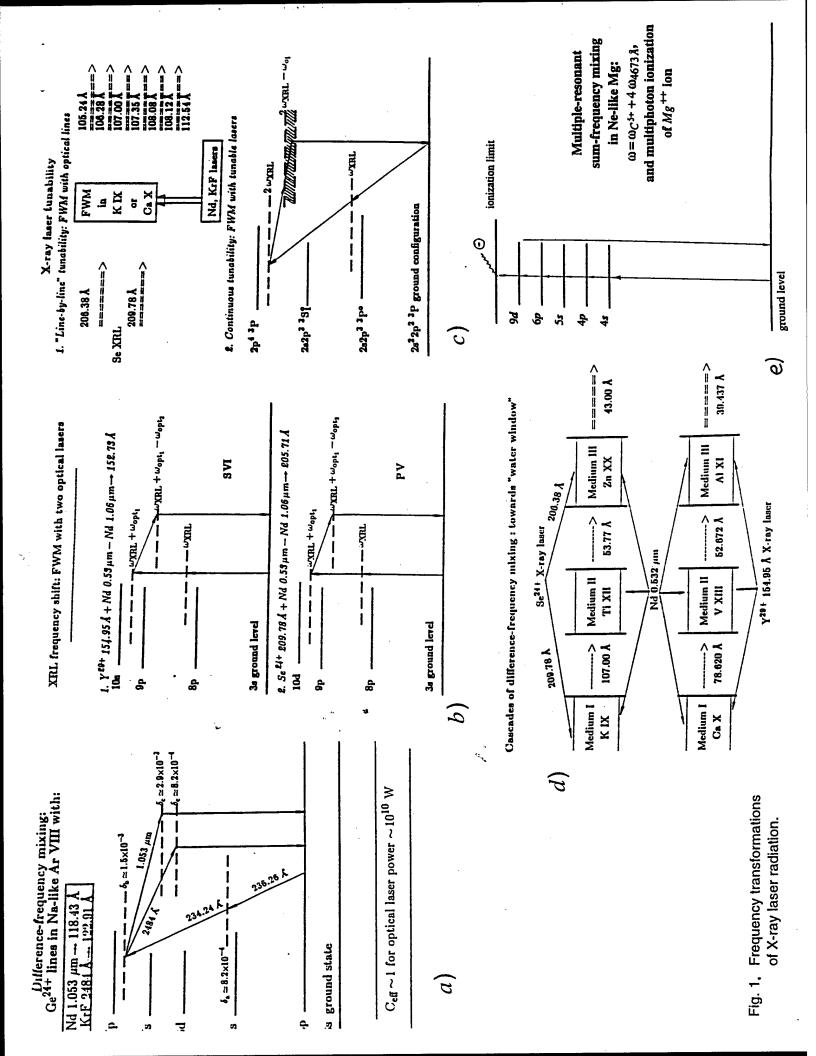
2.i.1. Resonant frequency transformations of short-wavelength coherent radiation in plasma [20,22,27,29,30,31,32,46,47]

Recently, a few theoretical papers on the feasibility of soft-X-ray laser frequency upconversion in plasma have been published by us and other researchers. In these papers, XRL frequency tripling, $\omega = 3\omega_{XRL}$, and near-doubling, $\omega = 2\omega_{XRL} - \omega_{opt}$ have been considered. (Here ω_{XRL} and ω_{opt} are frequencies of an XRL and a longer-wavelength laser, respectively; since $\omega_{opt} \ll \omega_{XRL}$, $\omega \sim 2\omega_{XRL}$ in the latter process.) It has been shown, in particular [33], that conversion efficiency C_{eff} of the X-ray frequency near-doubling might in some cases be be comparable to the conversion efficiency in visible domain, due to good multiple-resonant conditions and th participation of very powerful longer-wavelength lasers.

In this research, we have identified and estimated multiple-resonant plasma media for efficient frequency transformation of X-ray and an XUV laser radiation by a larger variety of four-wave mixing (FWM) processes. Our estimations show that high conversion efficiency is attainable with available short-wavelength output and contemporary plasma and X-ray optics technology. If realized experimentally, these nonlinear transformations may result in new X-ray coherent sources, including generation of coherent radiation at wavelengths as short as 22 Å, and in both "line-by-line" and continuously tunable X-ray lasing.

In the course of our research we have considered generation of about 30 new soft-X-ray lines. In addition to XRL frequency near-doubling [5], the following frequency transformations are expected to be among the most efficient [22,32] (see Fig. 1):

- (i) Difference-frequency mixing (2) of Ge XRL 232.24 $\,^{\circ}$ A and 236.26 $\,^{\circ}$ A with either Nd or KrF laser radiation in Na-like Ar (Fig. 1a). Very high conversion efficiency is expected at both 118.43 $\,^{\circ}$ A (with Nd laser) and 122.91 $\,^{\circ}$ A (with KrF laser) output wavelengths, due to excellent resonances. Note that the 122.91 $\,^{\circ}$ A pulse would be as short as KrF laser pulses are, that is, possibly < 1 ps. In collaboration with Prof. M. H. Key of Rutherford Appleton Lab, UK, we have considered a proof-of-principle experiment on DFM of Ge XRL developed in the UK [27].
- (ii) Frequency shift of Y^{29+} 155 % or Se^{24+} 206.38 % line by mixing with two optical lines (process $\omega = \omega_{XRL} + \omega_{opt_1} \omega_{opt_2}$) (Fig. 1b). In both cases, the two optical lines are the fundamental and the second harmonics of the same Nd laser. Efficiency of a few tens of percent is expected for conversion of both Y (152.73 % output) and Se (205.71 % output) lines.
- (iii) Cascades of highly-resonant difference-frequency mixing processes of X-ray and optical radiation. Such processes may provide a bridge between powerful Y, Se and Ge XRLs and the "water window" (radiation with wavelength between $\sim43\,\text{Å}$ and $\sim25\,\text{Å}$ believed to be the best for X-ray microscopy of living cells), with possible total photon conversion efficiency of a few percent. In one of the possible cascades (see Fig. 1c), mixing of two photons of Se XRL 209 Å line with one Nd laser photon in K IX yields 107 Å output. At the next step, mixing of two 107 Å photons with another Nd laser photon in Ti XII yields 53.77 Å radiation. Eventually, mixing of 53.77 Å, 206 Å, and Nd radiation in Zn XX produces 43 Å output.



(iv) Tunable coherent X-rays can also be generated by difference-frequency mixing of coherent X-ray and optical radiation (see Fig. 1d). By mixing of the two Se XRL lines with the lowest harmonics of Nd or KrF lasers in K IX or Ca X, one may attain "line-by-line" tunability near 107 $^{\circ}$ A with high C_{eff} (possible output at 105.24 $^{\circ}$ A, 106.28 $^{\circ}$ A, 107.00 $^{\circ}$ A, 107.35 $^{\circ}$ A, 108.08 $^{\circ}$ A, 108.12 $^{\circ}$ A, and 112.54 $^{\circ}$ A). Continuous tunability can also be achieved by FWM, now with a tunable longer-wavelength laser, similarly to generation of tunable VUV radiation. In soft-X-ray domain, however, both two- and one-photon resonances are necessary for a reasonable conversion efficiency. C-like ions may provide suitable media for this process. Expected conversion efficiency is of order of 10^{-5} for MW X-ray pumping and GW optical pumping.

2.i.2 Multiphoton processes in X-ray domain [30]

Multiphoton interactions of optical lasers with gases and plasma such as multiphoton ionization, which is now an important new area of atomic physics, or high-harmonic generation (HHG), a strong manifestation of nonperturbative nonlinear optics and an important new source of short-wavelength coherent radiation, have recently attracted much attention. We believe that parameters of existing X-ray lasers are already close to those required for observing similar multiphoton effects at much shorter wavelength, with similar potential impact on physics of highly-ionized atoms and X-ray nonlinear optics. As usual, the easiest to observe are resonantly enhanced processes. For instance, multiphoton absorption $\omega_{C^{5+}XRL} + 4\,\omega_{4673\,\text{Å}}$ in Ne-like Mg (see Fig. 1e) would be resonantly enhanced at each step so that very strong excitation and ionization of Mg^{2+} to F-like stage would take place even at modest C^{5+} XRL intensity. In the same media, strong multiphoton absorption is expected for Ge XRL + optical pumping.

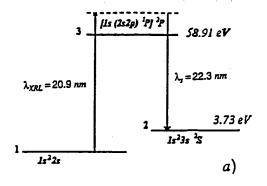
On the other hand, high-order harmonic generation is a non-resonant process, which requires high-intensity lasers even at longer wavelengths and, therefore, may seem to be totally out of reach for X-ray lasers. Yet, our estimates based on our two-level model of HHG [4,24,28,29] allowed us to suggest X-ray HHG at already available XRL output power (provided that a substantial improvement in the beam quality is attained in the experiment). Indeed, the most obvious manifestation of HHG is the presence of the "plateau": the intensities of generated harmonics are approximately the same within a large range of harmonics numbers. Our model [4] approximates a rare gas atom in HHG by a two-level atom and yields for the critical intensity I_{cr} , i. e. the pumping intensity necessary for the plateau formation: $I_{cr} \sim |d|^2/\omega_0 \omega$, where ω_0 and |d| are the transition frequency and the dipole moment of the model two-level system, respectively, and $\boldsymbol{\omega}$ is the frequency of the pumping laser. If one assumes that $|d| \sim \omega_0^{-1/2}$, then I_{cr} scales as ω_3 , provided the ratio of the pumping frequency ω to the ionization potential of the medium remains constant. In particular, it follows from the critical intensity being approximately equal to $2\times10^{13}~W/cm^2$ for HHG of an 616 nm laser in neutral argon [37] that the Y^{29+} XRL intensity of about 1.3×10¹⁸ W/cm^2 might be enough to observe X-ray HHG in Ar-like Kr. Such intensity would be attainable with the available Y XRL power of ~40 MW if it becomes possible to focus the beam to e. g. three times diffraction-limited spot of -3λ . Moreover, a few times larger intensity might generate a fully developed plateau such that the 21st harmonic (7.4%) would be as intense as the 5th harmonic.

2.i.3 X-ray stimulated electronic Raman scattering in non-ionized gases [5,7,8,25,36]

The vast majority of all the media proposed for X-ray resonant nonlinear optics have been plasmas. The feasibility of X-ray nonlinear effects in non-ionized materials, interesting theoretically and important experimentally (since it is much easier to work with neutrals), depends on whether resonances to XRL lines exist in neutral atoms, and whether the processes of interest would have time to develop before the medium becomes totally ionized by intense X-rays. We proposed for the first time two schemes for observing a resonant X-ray nonlinear effect, stimulated electronic Raman scattering (SERS), in non-ionized media -- He and Li vapor, and showed that very high conversion efficiencies may be achieved by operating in high pump energy regime in which total ionization of the media occurs in a time period much shorter than the pulse duration. We have studied in detail the dynamics of the process and predicted soliton-like pulses and precursors at the Stokes frequency at the photoionization front of pumping X-ray radiation [7].

X-ray SERS could be observed only if resonantly enhanced by tuning the pumping frequency close to some transition from the initial Raman level. Since X-ray laser photon energy (50-300 eV) is much larger than the binding energy of optical electrons in all the neutral atoms, we propose making use of so called core-exited atomic states. In particular, some double-exited levels of He and Li atoms are resonant to the powerful Se^{+24} 20.9 nm X-ray laser. Two transition schemes were considered (see Fig. 2): (i) He: 1 $^1S \rightarrow 2$ s2p $^1P \rightarrow 2^1S$ (the Stokes wavelength 32.2 nm), and (ii) Li: $1s^22s \rightarrow [1s(2s2p)^1P]^2P \rightarrow 1s^23s^2S$ (the Stokes wavelength 22.3 nm). Our estimates of small-signal gain have shown that significant Stokes output requires pump intensity of the order of $10^{12} - 10^{14}W/cm^2$, which is readily available; it would, however, fully ionize a medium within a fraction of the Se XRL pulse duration. Thus, effective Stokes generation can take place only at the leading edge of the laser pulse, before the full ionization sets in.

Fig. 3 depicts typical numerical solutions of Maxwell-Bloch equations for X-ray SERS in Li; normalized Stokes pulse energy flux is shown as a function of the cell length z for $N=10^{18} cm^{-3}$. One can see two distinct stages of this Raman process, the exponential growth and the saturation. In the exponential region the Stokes pulse width is constant and its peak coincides with the leading edge of the pump pulse whose velocity is limited by the photoionization to be smaller than c. In the saturation region, the Stokes pulse intensity is almost constant while the pulse width increases linearly with the distance c. An approximate analytical model developed by us, in particular, yielded an estimate of the optimal length of the Raman medium; e. g., for the attainable XRL pulse energy of 300 μ J, the optimal focusing for c 10¹⁸ c 10¹⁸



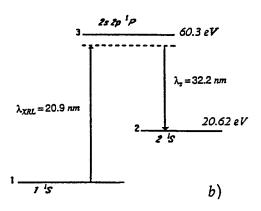
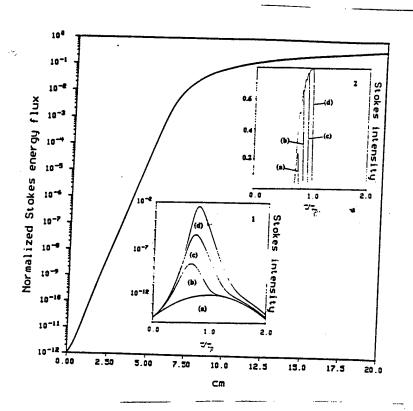


Fig. 2 X-ray Raman transtions in a) Li and b) He, resonant to Se XRL radiation.



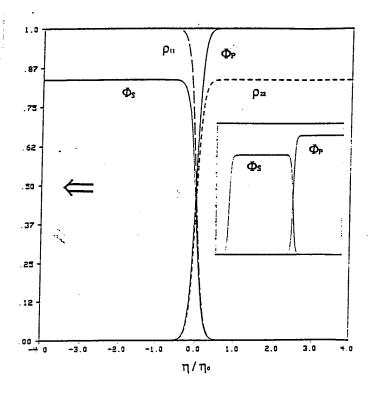


Fig. 3 Normalized Stokes energy flux $J_s(z)/J_p$ in Li as a function of the cell length z. Insets: Normalized Stokes intensity $I_s(z,\tau)/I_{p_{max}}$ as a function of normalized retarded time τ/τ_p in (a) exponential region; curves: 1 - z=0 cm; 2 - z=2 cm; 3 - z=4 cm; 4 - z=6 cm; in (b) linear region; curves: 1 - z=8 cm; 2 - z=12 cm; 3 - z=16 cm; 4 - z=20 cm.

Fig. 4 The pump, Φ_p , and Stokes, Φ_r , photon fluxes (normalized to $\Phi_p(\infty) = \Phi_0$), and the population of the ground, ρ_{11} , and excited, ρ_{22} , levels as a function of the normalize retarded time η/η_0 for IFSR soliton in He (for η_0 see in the text). The arrow indicate the direction of the pulse propagation.

the medium.

One of our major results is the finding that X-ray SERS can significantly inhibit the photoionization of the media and lead to formation of soliton-like pulses and precursors at the Stokes frequencies. Numerical solution for the intensities and populations for SERS in He (Fig. 4) shows that the coherent SERS significantly inhibits the photoionization of neutral atoms by X-ray radiation. This inhibition is due to the fact that a significant portion of neutral atoms ends up being "parked" at the upper excited level, whose photoionization cross section is very small. As a result, "ionization-front stimulated Raman" (IFSR) soliton is formed: while the trailing edge of the Stokes pulse travels with the same velocity as the photoionization front, its leading edge travels much faster, with the velocity of light in the neutral media. The length of such an almost rectangular pulse increases linearly with the distance traveled in media [5]. Therefore, in the X-ray IFSR soliton we have a strong "Stokes precursor", arriving at the end of the cell significantly ahead of pumping, which can be used for measurements, and for "pilot warning" of the trailing photoionization front. For propagating distance of 10 cm in Li, pump intensity of $10^{12} \ W/cm^2$ and $N = 10^{18} \ cm^{-3}$ (~ 0.1 atm at T=800K) the "warning time" is ~ $100 \ ps$.

2.ii. Phase-matching optimization of large-scale nonlinear frequency upconversion in neutral and ionized gases [2,10,11,18,24,28,33,42,45,48]

Bright, short-wavelength (λ < 1000 $^{\circ}$), coherent radiation would find numerous applications in areas as different as cell biology and material science. High-harmonic generation (HHG), $\omega_q = q \omega$, of optical and UV lasers in gas jets has succeeded in generating harmonics of a Nd:YAG laser (λ ~ 1 μm) at wavelength as short as 7.6 nm. The harmonic energy is, however, severely limited by very low conversion efficiency (defined as the ratio of harmonic power to the incident power); as a result, noticeable output requires very high pumping energy. Such low efficiency (below 10⁻⁷ for the highest to date applied power) is to a large extent due to poor phase matching. If phase-matched, HHG of widely available short-pulse high-intensity lasers could become a convenient, in principle table-top source of coherent, easily tunable short-wavelength radiation. Current experimental conditions of HHG are, however, very far from optimal, phase-matching-wise: the strong positive dispersion of even slightly ionized media requires, for the experimental design used, very loose focusing of the pumping beam, and, therefore, very high pumping energy. A similar problem has been successfully dealt with in third-harmonic generation (THG). Some approaches developed for THG and discussed recently in application to HHG, however, either would be of no help for very high-order harmonics, like using resonant refraction, or would yield phase matching factors many orders of magnitude lower than optimal, like using semi-infinite media.

In this research, we have proposed [2,10,11,18,24,28,33,42,45,48] two techniques that could improve radically the efficiency of large-scale nonlinear frequency upconversion: quasi-phase-matching of high-order harmonic generation in density-modulated media, and using

high-order difference-frequency mixing in plasma. The most important advantage of the proposed methods is that both techniques allow for optimal phase matching with tight focusing of pumping beams, which is detrimental for current approaches to frequency upconversion, with potential increase in conversion efficiency by several orders of magnitude. Optimal phase-matching conditions obtained by us in the perturbation limit are likely to hold for strong (stronger than atomic field) pumping fields as well [10,15,28].

2.ii.1. Optimal quasi-phase-matching for high-order harmonic generation in gases and plasma [11,18,45,48]

Recently, plasma density modulation has been proposed as a method to optimize phase matching for THG by relativistic plasma electrons. This idea is essentially a ramification of the well known method of quasi-phase-matching (QPM) proposed first in 1962 and extensively studied in the following years -- but almost exclusively for the second-harmonic generation in solids. This lack of interest in QPM in higher-order harmonic generation is, most likely, due to the existence of potentially much better and less cumbersome methods to optimize THG phase matching Many phase-matching techniques successful in THG are, however, of much less use for HHG, which makes QPM more attractive.

In this research, we have theoretically demonstrated the feasibility and potentials of QPM optimization of HHG by a focused beam in plasma or a gas whose nonlinear succeptibility and refractive index are spatially modulated, in particular through the medium density modulation. In order to obtain analytic results, we rely on the perturbation-theory expressions for the phase-matching factor; our results remain valid beyond perturbation limits as well, if some general assumptions hold regarding nonlinear polarization induced by strong laser field (see 2.ii.3).

We assume that the medium density modulated along the beam propagation axes z in such a way that the refractive index can be written as $n(u)=1+\tilde{n}\left[1+A\cos\left(au\right)\right]=n_0+\tilde{n}\,A\cos\left(au\right)$, where u=2z/b, $n_0=1+\tilde{n}$ is the ambient refractive index, \tilde{n} is proportional to the ambient medium density; and the nonlinear succeptibility responsible for the qth harmonic generation, $\chi^{(q)}$, is spatially modulated as $\chi^{(q)}(u)=\chi^{(q)}_0\left[1+A\cos\left(au\right)\right], \quad a=\pi b/\lambda_m$, where λ_m and A<1 are the modulation wavelength and amplitude, respectively, $\chi^{(q)}_0$ is the ambient (unperturbed) nonlinear succeptibility. Then, if a beam is tightly focused $(b\ll L)$ to a small confocal parameter in a not too dense plasma, or in a neutral gas, then optimal modulation wavelength is $\lambda_m^{opt} \approx = \pi b/(q-2)$. As an illustration, consider QPM for the 51st harmonic of a Ti:Sapph laser ($\lambda=0.8~\mu m$), which is near the middle of the harmonic plateau in the recent HHG experiments, and assume $b=100~\mu m$. Then, $\lambda_m^{opt} \approx 6.2~\mu m$ in plasma with $N_e \sim 10^{18}~cm^{-3}$.

An important advantage of QPM optimization is that it allows for tight focusing otherwise detrimental for HHG in rare gases and plasma. The incident intensity could then be easily increased by two orders of magnitude for the same pumping power by e. g. simply changing

the confocal parameter from – 1 mm used now, to readily attainable 100 μm . Without a general theory of phase matching beyond perturbation limits, or at least numerical simulations for a particular laser and a medium, it is impossible to calculate accurately the resulting increase in harmonic intensity. It is commonly assumed, however, that the intensity of high-order harmonics is approximately proportional to the 12th power of the incident intensity. Moreover, even for the currently used incident intensity, QPM optimization may significantly increase HHG conversion efficiency. Our estimates show that with recently reported plasma density modulation done by irradiating a grating with a ruby laser ($A \approx 0.08$, $\lambda_m \approx 2-6 \ \mu m$ in a plasma with $N_e \sim 10^{18} \ cm^{-3}$), QPM optimization might increase the harmonic intensity by a factor of ≈ 160 for the same pumping intensity.

2.ii.2. Large-scale nonlinear frequency upconversion by high-order difference-frequency mixing [2,10,18,24,28,33,42,45,48]

Even QPM, potentially the most promising method of HHG phase matching, would yield the phase-matching factor two orders of magnitude smaller than the factor attainable in media with negative dispersion. In other words, plasma remains an inherently hostile medium for harmonic generation, as far as phase matching is concerned. At the same time, substantial presence of free electrons at high laser intensities is practically unavoidable; moreover, theoretical models and recent experimental results suggest that HHG in ions would yield substantial output at much shorter wavelength than HHG in neutral atoms. It would be, therefore, much more advantageous not to fight an uphill battle with plasma dispersion, but use it as an ally. The need in such an ally is obvious from the necessity to compensate for large geometrical mismatch by large dispersion. Plasma dispersion is large; unfortunately, for HHG its sign is "wrong" (see Fig. 5). What we have proposed is using for large-scale nonlinear upconversion, instead of HHG, another nonlinear effect, high-order difference-frequency mixing (HDM) in plasma. HDM is the process of generating coherent radiation at the frequency ω , $\omega = m\omega_1 - l\omega_2$, (m and l are integers, $m \gg 1$) when laser beams with two substantially different frequencies ω_1 and ω_2 , interact in a nonlinear medium. We assume that $\omega_2 \ll \omega_1$ and m > l, so that shorter wavelengths could be attained by HDM of a given overall order (m+l). In this Section, we demonstrate that HDM presents much better potentials for large-scale nonlinear upconversion of the frequency ω₁ than HHG, in that HDM allows optimal phase matching in ionized media. Indeed, in the absence of close resonances to both incident and generated radiation, Δk for HDM is determined by free-electron dispersion only and can be written for collinear beams as $\Delta k_{HDM} \approx r_e N_e m [\lambda_1 - (l/m)\lambda_2]$. Obviously, by choosing (or tuning) the second laser and/or changing plasma density and the confocal parameters, one can in principle adjust phase mismatch Δk to any sign and/or size of the optimal $b\Delta k$.

To transform these qualitative remarks into quantitative estimations of optimal media and laser parameters, we have generalized, to the mixings of arbitrary orders, the theory of phase matching developed in [48] for the third-order mixing. On the basis of derived by us analytical

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segment 30 of the summary report 10 presents the lipid profile analysis and will be discussed further below. The third segment 40 of the summary report 10 presents the subclass profile analysis and will also be discussed further below.

As shown in Figure 2, the summary report 10 can also include a risk assessment report 10' containing information targeted to a more detailed risk assessment. Of course, the summary report 10 and the risk assessment report 10' as well as individual segments of each can be individually reported, presented or provided. In any event, as shown, the risk assessment report 10' includes a fourth segment 50 which presents supplemental risk factors, and a fifth segment 60 containing individual lipoprotein subclass levels. The summary report 10 can also include an optional sixth segment 70 which can incorporate primary prevention risk assessment information which can predict long term (i.e., 10 year) coronary heart disease (CHD) risk percentages.

As shown in Figure 2A, a risk assessment report 10" can also include a seventh segment 80 directed to secondary prevention guidelines which can summarize high risk conditions and characterizations, such as atherosclerotic vascular disease and diabetes, and general lipid management goals. This secondary prevention information may help to assist medical personnel in alternative treatment and to alert as to potential high-risk behavior or conditions. As shown, the risk assessment report is rearranged to present the fourth segment 50, the sixth segment 60, and the seventh segment 80. The information in this sample risk assessment report 10" is from a different patient than the results shown in Figure 1 and 2.

In a preferred embodiment, the major lipoprotein constituent values and the selected subclass values are generated via the NMR spectral analysis discussed above. The data are typically obtained by processing a blood plasma or serum sample obtained from a subject. As such, as used herein the terms "blood" and "plasma and "serum" sample are interchangeable, as each is suitable for obtaining the desired NMR spectroscopy signal.

Turning now to Figure 3, a preferred embodiment of the lipid profile or second segment 30 of the summary report 10 is shown. The patient-specific lipid

value results of total cholesterol 31, LDL cholesterol 32, HDL cholesterol 33, and triglycerides 34 are listed and arranged in aligned order from a top portion 30a of the second segment to a bottom portion 30b of the second segment. Preferably, alongside the listed order of the total cholesterol, LDL, HDL, and triglycerides, 31, 32, 33, and 34, respectively, the associated actual measured values 31a, 32a, 33a, and 34a are also serially aligned. Preferably, the values 31a, 32a, 33a, 34a are each displayed in a box 31b, 32b, 33b, 34b. Of course, the values 31a, 32a, 33a, and 34a may otherwise be presented, but are preferably presented in a visually enhanced format (such as via bold, italics, shaded, font (size, type), circled, underlined, colored or highlighted by other visual enhancement means) to provide ready visual recognition of the patient-specific results.

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As is also shown in Figure 3, the second segment 30 also preferably includes risk assessment guidelines 35 which represent a relative reference, guideline, or "yardstick" of the patient's value as compared to targeted values. Preferably, the risk assessment guidelines 35 divide the respective measured patient value for each of the total cholesterol 31, LDL 32, HDL 33, and triglycerides 34 into three different categories 36 of risk associated with a predetermine range of values (shown as measured in mg/dL). These predetermined range of values are based on predetermined test criteria.

As shown, the three categories for total cholesterol 31 and LDL 32 are labeled desirable 36a, borderline-high 36b, and high 36c. As shown, for total cholesterol 31, the desirable 36a category is defined as a value less than 200. For LDL 32, the desirable category 36a, is defined as a value less than 130. The borderline-high category 36b is defined as a range of values between 200-239 for total cholesterol 31 and between 130-159 for LDL 32. The high category 36c is defined as 240 or greater for total cholesterol 31 and 160 or greater for LDL 32.

Referring again to Figure 3, the HDL categories 36 are labeled as negative risk factor 36d, intermediate 36e, and positive risk factor 36f. The negative risk factor 36d is defined as a value of 60 or greater, the intermediate risk category 36e is defined as a value between and including 35-59, and the positive risk factor 36f is defined as a value less than 35.

The triglycerides categories 36 are labeled as normal 36g, borderline-high 36h, and high 36i. The normal category 36g is defined as a triglyderides value 33 of less than 200, the borderline-high category 36h is defined as a value between 200-400, and the high category 36i is defined as a value greater than 400 (but typically below 1000).

Preferably, the predetermined test criteria or targeted or ranges of values associated with each category of risk 36a-36i are defined to correspond to current National Cholesterol Education Program (NCEP) guidelines for primary prevention of coronary heart disease. See National Cholesterol Education Program, Second Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel II), Circulation 1994; 89:1329-1445. Of course, other suitable values or definitions can also be used, such as population based norms or other targeted based norms.

Preferably, as shown in Figures 1 and 3, the risk category 36 which corresponds to the patient value is visibly enhanced so that a reader can readily discern the category associated with the patient specific result (i.e., a visually enhanced risk category 38). For example, a person reviewing the patient-specific results shown in Figure 3 can readily discern that the patient results indicate that the patient is "high risk" in one category (LDL cholesterol 32), intermediate/borderline in two categories (cholesterol 31 and HDL cholesterol 33), and desirable in the other category (triglycerides 34). Further, a reviewer could readily discern how close the measured value is to the next adjacent risk category for each value 31, 32, 33, 34, which can also facilitate a more complete understanding of the results.

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Preferably, as shown, the risk assessment 35 is formatted so that the three risk categories 36 for each measured value are similarly sized and configured and are arranged serially over or under the adjacent measured value. In this way, each of the categories 36 for each measured value is positionally vertically aligned. The "low" or "negative/good" risk values 36a, 36d, 36g are positioned on one edge of a risk bar 36' and the "high" or "bad/positive" risk values 36c, 36f, 36i are positioned at the opposing edge of the risk bar 36'. This presentation yields an

aesthetic, easily readable format and informational horizontal continuum of risk characterization associated with the patient's results. As is also shown, the summary report 10 (or one or more of the segments 20, 30, 40) can include a descriptive comment portion 39 which discusses slight differences which may be observed from NMR spectral measurements compared to conventional or standard tests.

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Turning now to **Figure 4**, a preferred embodiment of the third segment **40** of the summary report **10** presenting the subclass profile is shown. The third segment **40** preferably includes four measured subclass variables, the subclass variables being labeled as LDL size **41**, LDL particles **42**, large HDL cholesterol **43**, and large VLDL triglyceride **44**. The LDL size value **41a** is shown as measured in nanometers (nm). The LDL particles value **42a** is shown as measured in nanomoles per liter (nmol/L) while the large HDL cholesterol value **43a** and the large VLDL triglyceride value **44a** are measured in milligrams per deciliter (mg/dL).

As for the lipid profile results discussed for the second segment 30 above, each of the measured values 41a, 42a, 43a, 44a are preferably presented in a visually enhanced manner 41b, 42b, 43b, 44b (the results are shown as visually enhanced or offset by a frame or box).

In a preferred embodiment, the third segment 40 also includes a risk assessment portion 46 where the measured results 41a, 42a, 43a, and 44a are visually enhanced and related or compared to predetermined criteria or values. For example, the LDL size result 41a is associated with three risk categories 46a, 46b, 46c. The risk categories 46a, 46b, 46c are defined by a pattern (A, AB, or B, respectively) associated with the particle size. The first category 46a is Pattern A, which is defined as a lower risk pattern associated with large particle sizes of 20.6-22.0 nm. The second category 46b is Pattern AB which is defined as an intermediate risk and corresponds to a particle size of 20.4-20.5 nm. The third risk category 46c is Pattern B and is defined as a higher-risk category and corresponds to smaller particle sizes of between 19.0-20.3 nm.

As shown, the remaining subclass measured values 42a, 43a, 44a, are displayed on a horizontally oriented line graph 46'. Preferably, each line graph 46'

plots the patient's results to illustrate whether the result indicates a higher or lower risk of CHD. In the embodiment shown, the graph is used to compare the patient measured result against a percentage of the general population having higher or lower levels of the measured value. Preferably, as shown, the line graphs 46' are plotted such that the results show a greater risk aligned at the right edge of the graph 46'. Stated differently, whether a higher or lower value indicates a higher risk of CHD, each of the line graphs 46' are defined to present the measured value such that the higher risk of CHD is at the same edge of the line graph and the higher and lower risks are thus visually aligned.

For example, the LDL particles 42a and the large VLDL triglyceride values 44a are graphed corresponding to percentage of the population having lower values 42c, 44c while the large HDL value 43a is graphed corresponding to the percentage of population having a higher value 43c. Nonetheless, as shown, the line graphs 46' are oriented and plotted such that the higher risk of CHD is aligned along the right end portion of the line graph. As shown, the patient results illustrate that 94% of the population has a lower LDL particle value 42a, 71% of the

population has a higher large HDL value 43a, and 78% of the population has a

lower large VLDL trigylceride 44a level.

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In a preferred embodiment, the population values are based on scientific results obtained from subjects in the Framingham Offspring Study. See Wilson et al., Impact of National Guidelines for Cholesterol Risk Factor Screening. The Framingham Offspring Study, JAMA, 1989; 262: 41-44. Of course the values presently defined for the risk assessment 36, 46 portion of the summary may change over time and more or alternate risk categories may be added. Further, the actual ranges or definitions associated with the risk category values of one or more of the lipid panels or subclass categories may change over time and the present invention is not intended to be limited thereto.

The order of the measured values 31a, 32a, 33a, 34a, 41a, 42a, 43a, and 44a may be alternately arranged in the summary report 10. In addition, the layout of the results may be alternately oriented (such as in vertical segments). Of course,

the second segment 30 (lipid profile) or the third segment 40 (subclass profile) may be provided alone depending on a customer's specifications.

It is also preferred that the report include a discussion of "flagged" or potential increased risk factors identified by the subclass values 41a, 42a, 43a, 44a as compared to predetermined risk assessment criteria. For example, as shown in Figure 5, a supplemental risk factor segment 50 can be included in the summary report 10°. The supplemental segment can include a preliminary informational introduction 50a which notes that coronary heart disease risk can significantly increase when there is a clustering of metabolic abnormalities not detected by standard lipid measurements. The supplemental risk segment 50 summarizes the presence of a metabolic profile associated with a higher level of risk than indicated by the LDL cholesterol value 32a. In a preferred embodiment, the "clustering" is indicated by a mark 51a, 52a, 53a, 54a in a corresponding subclass box 51b, 52b, 53b, 54b.

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As shown, this supplemental risk factor segment 50 includes a summary 50' for subclass values indicating abnormalities which indicate increased risk, *i.e.*, Pattern B small LDL 51, elevated number of LDL particles 52, low level of large HDL 53, and elevated level of large VLDL 54. As shown, if the summary 50' is selected (shown as positive with a "check mark" proximate to the category), then the CHD risk is increased. An informational guideline 51c, 52c, 53c, 54c, for the abnormal values is positioned proximate to the subclass box.

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In an alternative embodiment (not shown), a computer program can be configured to provide the analysis and risk assessment in a manner in which it can suppress non-abnormal results and provide only abnormal results in this segment 50°. Thus, if a patient has two "abnormal" or elevated risk values associated with the subclass readings, then only those two subclasses will be printed on this segment 50 of the summary report 10.

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In any event, as indicated for the small LDL variable 51, small LDL size (Pattern B) is a hallmark of the "atherogenic lipoprotein phenotype" and confers approximately a three-fold higher risk compared to the large LDL trait (Pattern A). There is evidence that suggests that small LDL particles may be inherently more

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atherogenic than large LDL. As regards an elevated number of LDL particles 52 (shown as for a value corresponding to the upper 33% of the population), unlike LDL cholesterol, LDL particle concentration (related closely to plasma apo B level), may be the single best indicator of LDL-associated CHD risk and the best target of risk reduction therapy. See Lamarche et al., Circulation 1996; 94:273-278. The supplemental risk factor segment 50 can also indicate the presence of low levels of large HDL 43. Low levels of large HDL 43 (shown as a value corresponding to the lower 33% of the population) may be a positive risk factor, as only larger HDL subclass particles appear to protect against CHD -- whereas small HDL may even be atherogenic. Therefore, large HDL, rather than total HDL cholesterol, may be a more sensitive risk factor. See Freedman et al., Arterioscler. Thromb. Vasc. Biol. 1998; 18:1046-53. Similarly, as shown, elevated levels of large triglyceride rich VLDL particles 54, appear to be associated with coronary artery disease (CAD) severity, substantially independent of plasma triglycerides. High concentrations of large VLDL in fasting plasma may be a marker for delayed chylomicron clearance (postprandial lipemia).

As shown in Figures 2 and 6, the summary report 10 may also include a fifth segment 60 showing a graphical representation of the subclass levels provided by NMR analysis. Referring to Figure 6, the fifth segment 60 divides the information into three groups of subclasses, VLDL triglyceride subclasses 61, LDL cholesterol subclasses 62, and HDL cholesterol subclasses 63. Each of the three subclasses 61, 62, 63 are further divided to graphically portray selected or grouped results. As shown, the VLDL triglyceride subclass 61 is divided into three groupings, a large VLDL subclass 61a (shown with a concentration or value of 30), a medium VLDL subclass 61b (shown with a value of 74), and a small VLDL subclass 61c (shown with a value of 4). The LDL subclasses 62 shown in Figure 6 include an IDL cholesterol subclass 62a (shown with a value of 9), a large LDL cholesterol subclass 62b (shown with a value of 31), a medium LDL cholesterol subclass 62c (shown with a value of 15), and a small LDL cholesterol subclass 62d (shown with a value of 110). The HDL subclasses shown are large HDL cholesterol 63a (shown with a value of 21) and small HDL 63b (shown with a

value of 21 For each subclass level shown 61a-c, 62a-d, 63a-b, the level measured in mg/dL are provided in text form at the top of the respective bar. The height of the bar gives the percent of population with lower levels of the graphed value. Advantageously, the HDL cholesterol subclass grouping can visually indicate the breakdown of the constituents of the overall HDL class 33 (value 42) shown on the summary report 10 to indicate the correspondence between the two subclasses to the overall HDL number. As shown, the results indicate an even amount of small HDL cholesterol 63b versus large HDL cholesterol 63a. Of course, other groupings or different subclass information may be separated out such as the separable subclass information shown in Figure 9, as will be discussed further below.

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The risk assessment report 10' may also include a sixth segment 70 addressing the primary prevention risk assessment for an individual. Referring to Figure 7, the sixth segment 70 incorporates certain behavioral and medical background of an individual with the lipid profile and subclass values. For example, a patient's age, smoking history, blood pressure, LDL value 32 and HDL value 33, and whether he or she has diabetes, and/or other risk pertinent information such as whether a blood relative has diabetes or CHD. A risk factor value is assigned to each of these parameters. Additionally, positive risk factors can be assigned a negative risk value (Figure 7A). Examples of positive risk factors include whether the patient actively exercises at least three days per week. has a high HDL cholesterol level 33a, has a Pattern A LDL size 41a, and has elevated levels of large HDL 43a). The positive and negative risk factors can be added to yield an overall risk value. In any event, a percentage based predictive CHD risk is generated corresponding to the total calculated risk. A target norm for the patient's age and gender can also be provided. In a preferred embodiment, the relative "negative" risk factors and predictive analysis is generated as described by Wilson et al., in Prediction of Coronary Heart Disease Using Risk Factor Categories, May 12, 1998 (copyright 1998 American Heart Association, Inc.).

As also shown in **Figure 7**, the risk of coronary heart disease is presented in several different percentage-based risk evaluations. A first risk **76a** is as indicated by the risk point total. A second risk **76b** is a "desirable risk", i.e. the

risk associated a non-smoking, non-diabetic person of the same gender and age having optimal blood pressure (less than 120/80), LDL cholesterol of 100-129 mg/dL, and HDL cholesterol of 55mg/dL. A third risk 76c is a "projected" risk to provide an age accounting balancing of risk (age typically being the single largest risk contributor as indicated in the risk factor chart). Thus, the third risk 76c evaluation can help provide a helpful basis for managed care assessment. A fourth risk 76d can also be included to provide a desirable risk at age 60 (one indicative of only age-related risk conditions). The age standard for persons under the 60 year mark can establish a more clear assessment of the risk a person with the measured values has for coronary heart disease. Advantageously, a patient may take more immediate steps to attempt to reduce the indicated exposure risk when presented with a longer-term standard reference risk.

The summary report 10" may also include a seventh segment 80 which is directed toward secondary prevention guidelines. As shown in Figure 8, the sixth segment presents a discussion 80a on special risk considerations for patients with established coronary heart disease, other atherosclerotic vascular disease, or diabetes. These patients are considered to be at particularly high risk as measured by the NCEP guidelines. For patients having one or more of these conditions, the present recommendations are lipid management to reduce LDL cholesterol to under 100 mg/dL. The corresponding NMR LDL particle concentration target is 1100 nmol/L. For patients with small LDL (Pattern B) and a clustering of the supplemental risk factors 50 discussed above, it can be especially important to reach these LDL goals. Smoking cessation, increased exercise, healthy diet, and blood pressure control can also be considered important treatment goals.

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Figure 9 graphically illustrates some of the subclass information provided by NMR analysis according to the present invention. This graph also shows the present medical understanding of the relationship between various lipoprotein subclass levels and CHD risk. The plus signs represent a positive association with disease (larger size signs indicating subclasses conferring higher risk). The higher levels indicating a higher risk. The minus signs represent a negative association, higher levels equals a lower risk. In a preferred embodiment, certain of the

individual subclass information shown is combined with other subclass information shown to provide the subclass groupings described above for Figure 6.

As discussed above, a preferred embodiment of the summary report 10 includes portions of the subclass information shown in Figure 8 (42, 43, 44) and also includes LDL size 41. Of course, the summary report 10 can include other subclass information within the scope of this invention. Advantageously, the instant reporting system and product can be used to provide important patient-specific information in an easy to assess manner and can be generated on a mass commercial production basis. Of course, some or part of this information may be presented in a computer readable medium or hard or paper report.

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Figure 10 illustrates a flow chart of methods, apparatus (systems) and computer program products according to the invention. It will be understood that each block of the flowchart illustration, and combinations of blocks in the flowchart illustrations, can be implemented by computer program instructions. These computer program instructions may be loaded onto a computer or other programmable data processing apparatus to produce a machine, such that the instructions which execute on the computer or other programmable data processing apparatus create means for implementing the functions specified in the flowchart block or blocks. These computer program instructions may also be stored in a computer-readable memory that can direct a computer or other programmable data processing apparatus to function in a particular manner, such that the instructions stored in the computer-readable memory produce an article of manufacture including instruction means which implement the function specified in the flowchart block or blocks. The computer program instructions may also be loaded onto a computer or other programmable data processing apparatus to cause a series of operational steps to be performed on the computer or other programmable apparatus to produce computer implemented process such that the instructions which execute on the computer or other programmable apparatus provide steps for implementing the functions specified in the flowchart block or blocks.

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Accordingly, blocks of the flowchart illustrations support combinations of means for performing the specified functions and program instruction means for

performing the specified functions. It will also be understood that each block of the flowchart illustrations, and combinations of blocks in the flowchart illustrations, can be implemented by special purpose hardware-based computer systems which perform the specified functions or steps, or combinations of special purpose hardware and computer instructions.

As shown in Figure 10, lipoprotein measurement values are obtained from a patient or subject, the values include at least one subclass value (Block 810). Preferably, an NMR spectral analysis is performed on a blood plasma sample and the lipoprotein values measured include the major lipoprotein constituents (total cholesterol, HDL, LDL, and triglycerides) as well as selected subclass values. The patient specific at least one subclass value is compared to predetermined test criteria to determine whether the value is associated with a higher or lower risk of developing coronary heart disease (Block 820). Preferably, the test criteria employed for the lipoprotein results (including the lipoprotein subclass values) correspond to a defined level of risk (low to high) of developing CHD. Preferably, the predetermined test criteria are based on scientific target "norms" or population based norms associated with higher or lower risks of CHD. These values may change over time or can be alternately identified for patients with increased secondary risk factors.

For example, if a patient has established CHD, athersclerotic vascular disease, and/or diabetes, the "risk" criteria and values of certain constituents or subclasses may be lowered on the summary report relative to a patient without said identified diseases such that a "high" risk value may be associated with a lower value (optional **Block 830**). This report's ability to automatically adjust or lower the risk value based on preexisting conditions can help alert the physician that this patient is subject to stricter lipid management or protocol by visually indicating the lower risk factor value targeted for this-individual. Generally, the test criteria may be set in a controlled revision software format which can be updated as NCEP guidelines or current medical analysis updates risk related information or values.

As shown in Figure 10, the next step is to determine the level of risk associated with the lipoprotein subclass value(s) (i.e., whether it is identified as

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being associated with increased-risk (and/or reduced-risk) of developing coronary heart disease) (Block 840). The NMR spectroscopy measured lipoprotein results are presented with a risk category associated with the measured result visually enhanced in a two-dimensional window for easy recognition thereof (Block 850). The two-dimensional window can be a display section on a computer screen, display monitor, or electronic or hard copy or a commercial report portion or segment. Advantageously, the customized display or report can be automatically generated or mass produced such as at a commercial facility or laboratory. As shown in Figure 1, it is preferred that each of the risk analysis information associated with the measured value be presented such that the "high" or elevated risk information is visually enhanced and aligned along one side (the same side as the other risk information for the other values) of the report or display.

Optionally, as indicated by **Blocks 870**, **875**, **880** and **885**, additional risk assessment information can also be provided. For example, a supplemental risk assessment for selected abnormal or higher risk subclass results can be provided (**Block 870**). This supplemental risk assessment can customize the report to provide more detailed information regarding selected or grouped subclass variables (such as LDL size or particles, large HDL, and/or large VLDL triglycerides, or atherogenic dyslipidemia). Similarly, a subclass level risk assessment can provide a graphic and textual breakdown of certain subclass groupings or selected subclass data (**Block 875**).

Alternatively, or additionally, a primary prevention risk assessment prediction assessment can be provided based on risk factors assigned to one or more of behavioral, medical, and/or selected lipoprotein measured constituent and/or subclass values (Block 880). As another alternative or addition, a secondary prevention guideline corresponding to recognition of the patient's diagnosis with certain high-risk medical conditions can be provided (Block 885).

Preferably, the method of the instant invention subdivides the major lipoprotein constituents and the LDL pattern separately into at least three risk categories each. It is also preferred that, the LDL particles 42, the large HDL value 43 and the large VLDL triglyceride value 44 are compared to a population based-

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norm and a line graph illustrates the actual measured result compared to the population with higher or lower levels of the measured value.

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The behavioral or medical input can be electronically input or input via a user at the lab or report site (for example, at a blood depository or lab where the blood or plasma sample is taken from a patient). It is typical that an identification number (bar-coded) is assigned to the vials for tracking. Accordingly, a hard copy or electronic data can also be identified such as with the same identification number. Once received at the central processing facility or NMR spectroscopy laboratory, the electronic data can be entered into the facility computer and matched with the lipoprotein measurements, and a customized patient profile summary report can be conveniently generated (either in one or more of soft or hard copy). In one embodiment, the summary report can be encrypted and emailed in electronic format to a physician's address for contemporaneous data reporting. Of course, the patient can be identified by a "permanent" number to track trend or drug therapy or other treatment impact over time. Additionally, a data base can be kept to analyze population trends (age, location, etc., versus one or more of the identified risk factors represented by a subclass and/or constituents) to provide important indicators of the population for medical use.

In an additional preferred embodiment (shown in Figure 11) a summary report 10" (shown as the coronary heart disease report) is similar in some respects to the summary reports 10, 10' discussed above. In this embodiment, the second segment 30' is a lipid profile that provides lipid profile values which are determined by measuring plasma lipoprotein levels directly by NMR, then converting concentrations to cholesterol or triglyceride units assuming that each lipoprotein has a normal lipid composition as will be appreciated by one of skill in the art. For most patients, NMR and standard lipid panel values will closely agree. Patients with certain metabolic abnormalities or elevated triglycerides may have cholesterol-depleted LDL. In these cases LDL concentrations determined by NMR may likely be higher than those inferred by conventional or standard LDL cholesterol tests.

In this embodiment, the lipid profile segment 30' includes total cholesterol 31, LDL concentration 32' (cholesterol equivalents), HDL concentration 33'(cholesterol equivalents), and triglycerides 34. Again, each of the associated values 31a', 32a', 33a', and 34a' are accentuated such as by positioning them in aligned order in a respective adjacent box 31b, 32b, 33b, and 34b, respectively. Further, each of the values is preferably horizontally aligned with at least three risk categories 36, the risk category associated with the determined value being accentuated for ease of reference as discussed above. Preferably, the risk categories are predetermined to correspond to the current NCEP risk categories. For example, "high" risk category generally represents a value which is >80% of the population. Similarly, the intermediate or borderline risk range is above 50% and 80% or below, while the desirable risk range is 50% or below.

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As shown, it is also preferred that the LDL concentration 32' include four risk categories, the fourth 36d' being an "optimal" value for secondary prevention (preferably set to a target value which is at a value of 20% or below the general population). This secondary prevention guideline is directed toward patients with established coronary heart disease, diabetes, or other atherosclerotic diseases as discussed above. Thus, this secondary guideline or "optimal" risk visual illustration can remind a treating physician of the reduced target value and can also facilitate a visible reminder for the patient, each of which can keep the secondary reduction target in the forefront of patient counseling thereby facilitating ongoing monitoring and reinforcing the importance of aggressive therapy (behavioral changes or other remediation) for a high-risk patient. This optimal box 36d' can be automatically accentuated in "red-line" or other accent as appropriate (such as via patient history data input) to remind the patient and/or physician that the patient is identified as a patient meeting the criteria for this target value reduction. Thus, for example, for a patient with diabetes, the LDL concentration risk categories 36 may bold or accent two-risk boxes, the "optimal" box with no value (for cases where a patient's result is above this value) and the actual risk box indicating the patient's actual value (not shown). Alternatively, the optimal box 36d' can be

programmed in the computer generated report to be suppressed on a non-relevant patient's report (also not shown).

As is also shown in **Figure 11**, the report **10**" preferably also includes a third segment **40**" which is a subclass profile providing predetermined lipoprotein constituent results. As shown, the subclass profile includes, in longitudinal serial order, LDL particles **42**", LDL size **41**", large HDL (cholesterol) **43**", and large VLDL (triglyceride) **44**".

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Preferably, this subclass profile segment 40' is configured to mirror the lipid profile (second segment 30') listed constituent order (for easier crossreference). Thus, as shown, a patient with a borderline reading on the LDL concentration value 32' (borderline risk) can then refer to the below listed subclass profile and note that the NMR measurement breakdown of the LDL concentration value 32a' really indicates that he or she is high risk both in LDL particles 42' and LDL size 41'. Similarly, the HDL concentration 33' referenced to the large HDL cholesterol 43' indicates a good correspondence (the large HDL being less than 18). Again, the risk categories for LDL particle concentration categories in the subclass profile 40' are set to correspond to the NCEP risk categories for LDL cholesterol (on a percentile equivalence basis) and can provide a constructive alternate target for therapy consideration or monitoring purposes (preferably, the risk percentages for each of the categories are about as shown, i.e., optimal 20%, desirable 50%, borderline/intermediate 80% or below (and above 50%), and high risk as above 80% of the population based on the Framingham study discussed above. The large HDL is the protective component of HDL and levels below the 20th percentile (less than about 18 mg/dL) indicate higher risk (positive risk factor) while levels above the 80th percentile (greater than about 42 mg/dL) indicate lower risk (negative risk factor). Elevations of large VLDL are related to delayed chylomicron clearance and higher CHD risk, and preferably, values above the 80th percentile (greater than about 33 mg/dL) define the "higher-risk" category. Figure 11A illustrates the summary report 10" with a modified subclass profile 401. As shown, the LDL particle constituent has been labeled "LDL Particle

Concentration" 42" and the adjacent text block 402 includes values associated with the particular percentile reference.

In contrast to the first embodiment discussed above, these summary reports 10" present the subclass profile as a segmented risk analysis presentation format 146 (rather than a risk percentage continuum). Preferably, the segment format 146 is configured to mirror that of the lipid profile 30°. That is, the risk characterization includes the same number of risk categories with the increased, positive, or high-risk category all being positioned to one side of the presentation format. Thus, a patient or physician can readily discern the risk category associated with the NMR results (preferably, the high-risk categories are all aligned along the right hand side of the report). As for the lipid profile section 30°, the results are preferably presented in a visually enhanced format, with each of the specific lipoprotein results 42a°, 41a°, 43a°, and 44a° being presented in a box 42b°, 41b°, 43b°, and 44b°.

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Stated differently, it is readily apparent at a glance that the patient with the NMR measurements provided in **Figures 11** or **11A**, has a high-risk subclass profile **40'** but only a single positive risk factor associated with the lipid profile panel **30'**. In practice, without a NMR subclass profile, a patient with this type of lipid profile may have been overlooked as a candidate for further review or potential behavior altering counseling (or even drug therapy) because of the number of borderline lipid measurement results. Preferably, as stated above, the actual numerical result is presented alongside the lipoprotein constituent while the risk categories associated therewith are horizontally oriented with the risk associated with the actual numerical result highlighted to indicate the risk level associated with that lipoprotein result.

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Figure 12 illustrates a preferred embodiment of a technical report 100 associated with NMR measured lipoprotein constituents. In order to provide a more representative indication of a patient's risk, it is desirable to provide an automatically (or semi-automatically) computer generated coronary heart disease (CHD) risk assessment module 150 as a portion of the lipid panel analysis (or even as a separate evaluative report). Preferably, the CHD risk assessment module

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includes two key identifiers 151, 152. The first key identifier 151 is analyzing whether the patient's LDL particle number is elevated compared to a predetermined level. Preferably, the predetermined elevated level is set at a value which is approximately equivalent to the upper 50% of the population (greater than about 1400 nmol/L). The module 150 also preferably includes the relevant risk test measurement positioned adjacent to the particular constituent 151a, 153a, 154a, 155a. This elevated LDL particle number 151 is a key identifier of coronary heart disease risk, and indeed, may be the single best indicator of LDL-associated CHD risk. See Generally, Lamarche et al., Circulation, 1996; 94:273-278. Of course, the "elevated" target value could be set at above 50%.

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The second key identifier 152 is termed "atherogenic dyslipidemia". As used herein, the term "atherogenic dyslipidemia" refers to an increased risk of CHD based on a clustering or confluence of NMR measured lipoprotein constituent or subclass abnormalities. Preferably, the presence or absence of atherogenic dyslipidemia is determined based on a predetermined level of at least three different NMR lipoprotein subclass or constituent values. In the past, the presence of elevated triglycerides has been used as a proxy to indicate the atherogenic dyslipidemia condition while plasma apo B protein level measurement techniques have been used to estimate the number of LDL particles. However, and advantageously, the NMR based lipoprotein measurements can provide more detailed, easier, and commercially reproducible lipoprotein component measurements. Using certain of these NMR component measurements individually (such as the determination of an elevated number of LDL particles) and in combination (to determine the presence of a clustering of abnormalities) can, thus, provide an easier and more reliable determination and assessment of a patient's risk for CHD.

In a preferred embodiment, the positive or affirmative match to test criteria for at least two of the three selected-lipoprotein subclass or constituent values results in a designation of atherogenic dyslipidemia. This NMR-based lipoprotein atherogenic dyslipidemia test criteria 152 can provide a more reliable analysis of a patient's risk for CHD over isolated component values. For example, a patient's

individual or component constituent or subclass values may all be insufficient to determine or provide a reliable indication of increased risk of CHD, but a clustering of certain abnormal conditions or results can indicate a higher-risk metabolic condition. Indeed, patients with a clustering of the lipoprotein subclass abnormalities shown (small LDL 153, low level of HDL 154, and elevated level of large VLDL 155) are at higher risk of CHD when risk identifier 151 is indicated, *i.e.*, when LDL particle numbers are elevated. Thus, the present invention uses positive matches for two or more of the plurality of lipoprotein constituent values listed to indicate the presence of the higher-risk metabolic condition.

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The CHD atherogenic dyslipidemia assessment preferably includes a test for small LDL 153 and low levels of large HDL 154. Small LDL 153 (Pattern B) is a hallmark of atherogenic dyslipidemia and confers about a three-fold higher risk compared to the large LDL trait (Pattern A). Evidence suggests that small LDL particles may be inherently more atherogenic than large LDL. An indication of a low level of large HDL 154 has a positive association with CHD. A low level of large HDL means a NMR derived value which is below the 50%, and more preferably means the value is below 35% (less than about 23 mg/dL). That is, only the larger HDL subclasses appear to be protective, whereas small HDL is positively associated with CHD. Therefore, large HDL, rather than total HDL cholesterol, may be a more sensitive risk factor and, indeed, an independently predictive marker for CHD in addition to being a factor which can assist in the determination of atherogenic dyslipidemia.

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Similarly, the CHD atherogenic dyslipidemia risk assessment preferably includes a test for elevated levels of large VLDL 155. Elevated levels of large, triglyceride-rich VLDL particles have been associated with the severity of CAD, independently of plasma triglycerides. High concentrations of large VLDL in fasting plasma are a marker for delayed chylomicron clearance (postprandial lipemia). "Elevated" for VLDL means the value is in the upper 50th percentile, and preferably means above about the 65th percentile (greater than about 17 mg/dL) or such as in the upper 33%.

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Additional or alternative lipoprotein subclass or constituent parameters may also be used as a test parameter for atherogenic dyslipidemia. Similarly, the percentile-based values are preferably as shown but may also be other values. For example, these values can be altered to reflect contemporary guidelines by the NCEP or other health organization, statistically valid tests or studies, scientific or empirical data and the like. As will be appreciated by one of skill in the art, the percentile values are preferably set to reflect an acceptable sensitivity/specificity test result. Figure 12A illustrates another embodiment with a modified risk assessment module 150'. As shown, the first key risk factor 151 is labeled "Elevated LDL Particle Conc.[entration]". The module 150' includes a modified test criteria over that in Figure 12 and also includes values rather than percentile references. The text in certain of the associated risk analysis is also modified from Figure 12.

The population percentile values described herein are from NMR data obtained from analysis of 3,437 subjects in the Framingham Offspring study. However, the present invention is not limited thereto. As noted above, these values may change over time, or other percentiles or values may be used.

As discussed for the report of Figure 2, the reports 100 shown in Figures 12 and 12A also preferably include a subclass graphic analysis segment 60' with grouped subclass data. As shown, the HDL results give a visual representation of the disparity of small (bad or harmful) HDL to the large (good) HDL. This patient is above the 75th percentile in (bad) small HDL and indeed has a positive risk indication across the spectrum of the lipoprotein subclass values (ignoring the low level of large HDL). Thus, this patient's overall conventional lipid profile is not reflective of his or her actual risk.

Figure 13 illustrates a hybrid summary report 110 with a subclass profile segment as shown in Figure 11A and a CHD risk assessment module as shown in Figure 12A. This report 110 provides an easy to read single page overview or summary of the most relevant heart-specific test measurement results.

Figure 14 schematically illustrates a system according to one embodiment of the present invention. As shown, the system includes an NMR measurement

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apparatus 500 for measuring the lipoprotein constituents of a patient's blood or plasma sample. A suitable method for determining the lipoprotein constituents is disclosed in U.S. Patent No. 4,933,844 to Otvos, entitled "Measurement of Blood Lipoprotein Constituents by Analysis of Data Acquired From an NMR Spectrometer" and U.S. Patent No. 5,343,389 to Otvos, entitled "Method and Apparatus for Measuring Classes and Subclasses of Lipoproteins", incorporated by reference above. The system also includes a computer means for generating an automatic lipoprotein report and determining CHD risk based on the NMR measured constituent values 525. The computer means then generates a customized lipoprotein report which includes information identifying the CHD risk attendant with the NMR derived lipoprotein constituent values 530. Preferably, the system is operably associated with a peripheral device such as another computer or internet or printer so as to transmit and print or display the customized report.

As will be appreciated by one of skill in the art, the present invention may be embodied as a method, data processing system, hard copy two-dimensional printed material report, computer screen display, or computer program product. Accordingly, the present invention may take the form of an entirely hardware embodiment, an entirely software embodiment or an embodiment which combines software and hardware aspects. Furthermore, the present invention may take the form of a computer program product on a computer readable storage medium having computer readable program code means embodied in the medium. Any suitable computer readable medium may be utilized including for example, hard disks, CD-ROMs, optical storage devices, or magnetic storage devices.

A portion of the disclosure of this patent document contains material which is subject to copyright protection. The copyright owner, LipoMed, Inc., of Raleigh, North Carolina, has no objection to the facsimile by anyone of the patent document or the patent disclosure, as it appears in the Patent and Trademark Office patent file or records, but otherwise reserves all rights whatsoever.

The foregoing is illustrative of the present invention and is not to be construed as limiting thereof. Although a few exemplary embodiments of this invention have been described, those skilled in the art will readily appreciate that

many modifications are possible in the exemplary embodiments without materially departing from the novel teachings and advantages of this invention. Accordingly, all such modifications are intended to be included within the scope of this invention as defined in the claims. In the claims, means-plus-function clauses are intended to cover the structures described herein as performing the recited function and not only structural equivalents but also equivalent structures. Therefore, it is to be understood that the foregoing is illustrative of the present invention and is not to be construed as limited to the specific embodiments disclosed, and that modifications to the disclosed embodiments, as well as other embodiments, are intended to be included within the scope of the appended claims. The invention is defined by the following claims, with equivalents of the claims to be included therein.

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